DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2000-08

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.325

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 9,933
b. FFY 2001 $ 121,532

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Part I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Part I

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement (Version XIX)

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Currently in review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bob Sharpe

14. TITLE:
Acting Deputy Director

15. DATE SUBMITTED:
September 15, 2000

16. RETURN TO:
Mr. Bob Sharpe
Acting Deputy Director for Medicaid
Agency for Health Care Administration
Post Office Box 12600
Tallahassee, Florida 32317-2600

Attention: Wendy Johnston

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 19, 2000

18. DATE APPROVED:
April 1, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Grasser

22. TITLE:
Associate Regional Administrator
Division of Medicaid & State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

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FLORIDA TITLE XIX INPATIENT HOSPITAL

REIMBURSEMENT PLAN

VERSION XIX

EFFECTIVE DATE: September 20, 2000

I. Cost Finding and Cost Reporting

A. Each hospital participating in the Florida Medicaid Hospital Program shall submit a cost report postmarked no later than 5 calendar months after the close of its cost reporting year. A hospital filing a certified cost report that has been audited by the independent auditors of the hospital shall be given a 30-day extension if the Agency for Health Care Administration (AHCA) is notified in writing that a certified report is being filed. The hospital cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII or Title V cost reporting, if applicable. A complete legible copy of the cost report shall be submitted to the Medicare intermediary and to AHCA, Bureau of Medicaid Program Analysis, Cost Reimbursement.

B. Cost reports available to AHCA as of March 31, 1990, shall be used to initiate this plan.

C. All hospitals are required to detail their costs for their entire reporting year making appropriate adjustments as required by this plan for determination of allowable costs. New hospitals shall adhere to requirements of Section 2414.1, Provider Reimbursement Manual, HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, Florida Administrative Code (F.A.C.) A prospective reimbursement rate, however, shall not be established for a new hospital based on a cost report for a period less than 12 months. For a new provider with no cost history, excluding new providers resulting from a change in ownership where the previous provider participated in the program, the interim per diem rate shall be the lesser of:

a. the class reimbursement ceiling, if applicable; or

b. the budgeted rate approved by AHCA based on Section III of this plan.

Interim rates shall be cost settled for the interim rate period. Interim per diem rates shall not be approved for new providers resulting from a change in ownership. Medicaid reimbursement is hospital specific and is not provider specific.

D. The cost report shall be prepared in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., except as modified by the method of reimbursement and cost finding of Title XVIII (Medicare) Principles of Reimbursement described in 42 CFR 413.5 - 413.35 (1998) and further interpreted by the Provider Reimbursement Manual HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., or as further modified by this plan.

E. If a provider submits a cost report late, after the 5 month period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 5 months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be affected retroactively.Medicare granted exceptions to these time limits shall be accepted by AHCA.

F. A hospital which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a clearly marked "final" cost report in accordance with Section 2414.2, HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C. For the purposes of this plan, filing a final cost report is not required when:

1. the capital stock of a corporation is sold; or

2. partnership interest is sold as long as one of the original general partners continues in the partnership or one of the original limited partners becomes a general partner, or control remains unchanged.

Any change of ownership shall be reported to AHCA within 45 days after such change of ownership.

G. All Medicaid participating hospitals, are required to maintain the Florida Medicaid Log and financial and statistical records in accordance with 42 CFR 413.24 (a)-(c) (1998). In addition, a separate log shall be maintained to account for concurrent and non-concurrent nursery days. For purposes of this plan, statistical records shall include beneficiaries' medical records. These records shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General of the State of Florida, the General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). Beneficiaries' medical records shall be released to the above named persons for audit purposes upon proof of a beneficiary's consent to the release of medical records such as the Medicaid Consent Form, Department of Health-Med Form 1005, as incorporated by reference in Rule 59G-5.080, (2), F.A.C.

H. Records of related organizations as defined by 42 CFR 413.17 (1998) shall be available upon demand to representatives, employees or contractors of AHCA, the Auditor General, GAO, or HHS.

I. AHCA shall retain all uniform cost reports submitted for a period of at least 5 years following the date of submission of such reports and shall maintain those reports pursuant to the record keeping requirements of 45 CFR 205.60 (1998). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes. Upon request for a copy of any cost report, the hospital involved shall be notified as to the person making the request and what is being

requested. Unless prohibited by a court of competent jurisdiction, the cost report shall be released to the requestor within a limited reasonable time from receipt of the request by the Agency for Health Care Administration. Reasonable time is defined as the time allowed to enable the agency to retrieve the record and delete exempt portions of the record.

II. Audits

A. Background

Medicaid (Title XIX), Maternal and Child Health and Crippled Children's Services (Title V), and Medicare (Title XVIII) requires that inpatient hospital services be reimbursed on a reasonable cost basis. To assure that payment of reasonable cost is being achieved, a comprehensive hospital audit program has been established to reduce the cost of auditing submitted cost reports under the above three programs, and to avoid duplicate auditing effort. The purpose is to have one audit of a participating hospital that shall serve the needs of all participating programs reimbursing the hospital for services rendered.

B. Common Audit Program

AHCA has entered into written agreements with Medicare intermediaries for participation in a common audit program of Titles V, XVIII and XIX. Under this agreement the intermediaries shall provide AHCA the result of desk and field audits of those participating hospitals located in Florida, Georgia, and Alabama.

C. Other Hospital Audits

For those hospitals not covered by the common audit agreement with Medicare intermediaries, AHCA shall be responsible for performance of desk and field audits.

AHCA shall:

1. Determine the scope and format for on-site audits;

2. Desk audit all cost reports within 6 months after their submission to AHCA;

3. Ensure all audits are performed in accordance with generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C. (10/94);

4. Ensure that only those expense items that the plan has specified as allowable costs under Section III of this plan have been included by the hospital in the computation of the costs of the various services provided under Rule 59G-4.150, F.A.C.

5. Review to determine that the Florida Medicaid Log is properly maintained and current in those hospitals where its maintenance is required;

6. Issue, upon the conclusion of each full scope audit, a report which shall meet generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C., (10/94), and shall declare the auditor's opinion as to whether, in all material respects, the cost submitted by a hospital meets the requirements of this plan.

D. Retention

All audit reports received from Medicare intermediaries or issued by AHCA shall be kept in accordance with 45 CFR 205.60 (1998).

E. Overpayments and Underpayments

1. Overpayments for those years or partial years as determined by desk or field audit using prior approved State plans shall be reimbursable to AHCA as shall overpayments, attributable to unallowable costs only.

2. Overpayments in outpatient hospital services shall not be used to offset underpayments in inpatient hospital services and, conversely,

overpayments in inpatient hospital services shall not be used to offset underpayments in outpatient hospital services.

3. The results of audits of outpatient hospital services shall be reported separately from audits of inpatient hospital services.
4. Any overpayment or underpayment that resulted from a rate adjustment due to an error in either reporting or calculation of the rate shall be refunded to AHCA or to the provider as appropriate.
5. Any overpayment or underpayment that resulted from a rate based on a budget shall be refunded to AHCA or to the provider as appropriate.
6. The terms of repayments shall be in accordance with Chapter 414.41, Florida Statutes.
7. All overpayments shall be reported by AHCA to HHS as required.
8. Information intentionally misrepresented by a hospital in the cost report shall result in the imposition of disciplinary action by the Florida Medicaid Program as provided for in Rule 59G-9.010, F.A.C.

F. Appeals

For audits conducted by AHCA, a concurrence letter that states the results of an audit shall be prepared and sent to the provider, showing all adjustments and changes and the authority for such. Providers shall have the right to a hearing in accordance with Section 28-106, F.A.C, and Section 120.57, Florida Statutes, for any or all adjustments made by AHCA.

III. Allowable Costs

Allowable costs shall be determined using generally accepted accounting principles, except as modified by Title XVIII (Medicare) Principles of Reimbursement as described in 42 CFR 413.5 - 413.35 (1998) (excluding the inpatient routine nursing salary cost differential) and the guidelines in the Provider Reimbursement Manual HCFA PUB. 15-1, as incorporated by reference in Rule 59G-6.010, F.A.C., -and as

further modified by Title XIX of the Social Security Act (the Act), this plan, requirements of licensure and certification, and the duration and scope of benefits provided under the Florida Medicaid Program. These include:

A. Costs incurred by a hospital in meeting:

1. The definition of a hospital contained in 42 CFR 440.10 (1998) (for the care and treatment of patients with disorders other than mental diseases) and 42 CFR 440.140 (for individuals age 65 or older in institutions for mental diseases), (1998) in order to meet the requirements of Sections 1902(a)(13) and (20) of the Social Security Act;
2. The requirements established by the Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 (b) (1998); and
3. Any other requirements for licensing under Chapter 395.003, Florida Statutes, which are necessary for providing inpatient hospital services.

B. Medicaid reimbursement shall be limited to an amount, if any, by which the per diem calculation for an allowable claim exceeds the amount of third party benefits during the Medicaid benefit period.

C. Hospital inpatient general routine operating costs shall be the lesser of allowable costs, direct and indirect, incurred or the limits established by HHS under 42 CFR 413.30 (1998).

D. Malpractice insurance costs shall be apportioned to Medicaid in the ratio of Medicaid Patient Days to Total Patient Days.

E. Under this plan, hospitals shall be required to accept Medicaid reimbursement as payment in full for services provided during the benefit period and billed to the Medicaid program; therefore, there shall be no payments due from patients. As a result, for Medicaid cost reporting purposes, there shall be no Medicaid

bad debts generated by patients. Bad debts shall not be considered as an allowable expense.

F. All physician orders and records that result in costs being passed on by the hospital to the Florida Medicaid Program through the cost report shall be subject to review by AHCA on a random basis to determine if the costs are allowable in accordance with Section III of this plan. All such orders determined by the Utilization and Quality Control Peer Review Organization (PRO) or the hospital's utilization review (UR) committee to be unnecessary or not related to the spell of illness shall require appropriate adjustments to the Florida Medicaid Log.

G. Surgical procedures identified by AHCA in Appendix E of the Hospital Coverage and Limitations Handbook, under Rule 59G-4.150, F.A.C., shall require prior authorization . Failure to meet the above requirements shall result in the disallowance of such charges associated with the surgical procedures. Appropriate adjustments shall be made to the Florida Medicaid Log.

H. The allowable costs of nursery care for Medicaid eligible infants shall include direct and indirect costs incurred on all days these infants are in the hospital.

I. The revenue assessments, and any fines associated with those assessments, mandated by the Health Care Access Act of 1984, Section 395.7015, Florida Statutes, shall not be considered an allowable Medicaid cost and shall not be allocated as a Medicaid allowable cost for purposes of cost reporting.

J. For purposes of this plan, gains or losses resulting from a change of ownership will not be included in the determination of allowable cost for Medicaid reimbursement.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, and 42 CFR 447.205 (1998), this plan shall be promulgated as an

Administrative Rule and as such shall be made available for public inspection. A public hearing shall be held so that interested members of the public shall be afforded the opportunity to review and comment on this plan.

B. For purposes of establishing reimbursement ceilings, each hospital within the state shall be classified as general, teaching, specialized,rural, or as a Community Hospital Education Program (CHEP) hospital. An inpatient variable cost county reimbursement ceiling shall be established for and applied to general hospitals. An inpatient variable cost class reimbursement ceiling shall not be applied to specialized, statutory teaching, rural, or CHEP hospitals. An inpatient fixed cost reimbursement ceiling shall be established for all hospitals except rural hospitals and specialized psychiatric hospitals. Out-of-state hospitals shall be considered to be general hospitals under this plan.

C. Reimbursement ceilings shall be established prospectively for each Florida County. Beginning with the July 1, 1991, rate period, additional ceilings based on the target rate system shall be imposed. The target rate ceiling shall be the approved rate of increase in the prospective payment system for the Medicare Inpatient Hospital Reimbursement Program as determined by the Department of HHS. For fiscal year 1991-1992, the allowable rate of increase shall be 3.3 percent. Effective July 1, 1995, the target rate ceiling shall be calculated from an annually adjusted Data Resource Inc. (DRI) inflation factor. The DRI inflation factor for this time period is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then

multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. These target ceilings shall apply to inpatient variable cost per diems (facility specific target ceilings) and county ceilings (county target ceilings) and shall be used to limit per diem increases during state fiscal years. The facility specific target and county target ceilings shall apply to all general hospitals. Rural, specialized, statutory teaching and Community Hospital Education Program (CHEP) hospitals are exempt from both target ceilings. D. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in H. below.

E. Changes in individual hospital per diem rates shall be effective from July 1 through December 31 and January 1 through June 30 of each year.

F. For the initial period, the last cost report received from each hospital as of March 31, 1990 shall be used to establish the reimbursement ceilings. For subsequent periods, all cost reports postmarked by March 31 and September 30 and received by AHCA by April 15 and October 15 respectively shall be used to establish the reimbursement ceilings. For the initial period within 20 days after publication, a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the proposed reimbursement ceilings. Subsequent rate periods shall not be automatically subject to public hearing.

G. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings. -

H. The prospectively determined individual hospital's rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.
2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date the rate was established, or if the change is not material.
3. Further desk or on-site audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.
4. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

I. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with 59-1.018 (4), F.A.C., and Section 120.57. Florida Statutes.

J. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling, except as provided for in Sections IV.B and C..

K. The agency shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by Section 1923 of the Act.

L. The agency shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age as required by Section 1923 of the Act.

V. Methods

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings for Inpatient Variable Cost.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk audits;
   b. To exclude from the allowable cost, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1998).
3. Determine allowable Medicaid variable costs defined in Section X of this plan.
4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30, or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) National and Regional Hospital Input Price Indices as detailed in Appendix A.
5. Divide the inflated allowable Medicaid variable costs by the latest available health, recreation and personal services component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.
6. Divide the results of Step 5 for each hospital by the sum of its Medicaid regular inpatient days plus Medicaid non-concurrent nursery days resulting in a variable cost per diem rate. Medicaid non-concurrent

nursery days are inpatient nursery days for a Medicaid eligible newborn whose mother is not an inpatient in the same hospital at the same time.

7. Array the per diem rates in Step 6 from the lowest to the highest rate for all general hospitals within the State with the associated Medicaid patient days.

8. For general hospitals in a county, set the county ceiling for variable costs at the lower of:

   a. The cost based county ceiling which is the per diem rate associated with the 70th percentile of Medicaid days from Step 7 times the FPLI component utilized in Step 5 for the county;

   b. The target county ceiling that is the prior January rate semester's county ceiling plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year.

9. Specialized, statutory teaching, and rural hospitals are excluded from the calculation and application of the reimbursement county ceilings in V.A.1 through 8., above..Community Hospital Education Program